

ATTACHMENTS

THERAPY SERVICES

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March 27, 1992

ATTACHMENT 1

NATIONAL HCFA 1500 CLAIM FORM SAMPLE

PICA										HEALTH INSURANCE CLAIM FORM										PICA									
1 MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER										14 INSURED'S ID NUMBER										FOR PROGRAM IN ITEM 11									
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)										3 PATIENT'S BIRTH DATE										4 INSURED'S NAME (Last Name, First Name, Middle Initial)									
Recipient, Im A.										MM DD YY M F										234567890									
5 PATIENT'S ADDRESS (No. Street)										6 PATIENT RELATIONSHIP TO INSURED										7 INSURED'S ADDRESS (No. Street)									
609 Willow St.										Self Spouse Child Other																			
CITY										8 PATIENT STATUS										CITY									
Anytown										Single Married Other										STATE									
STATE										Employed Full-Time Student Part-Time Student										STATE									
WI																													
ZIP CODE										TELEPHONE (Include Area Code)										ZIP CODE									
55555										(XXX) XXX-XXXX										()									
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10 IS PATIENT'S CONDITION RELATED TO										11 INSURED'S POLICY GROUP OR FECA NUMBER									
OI-P										a. EMPLOYMENT? (CURRENT OR PREVIOUS)										a. INSURED'S DATE OF BIRTH									
										YES NO										MM DD YY M F									
12 OTHER INSURED'S POLICY OR GROUP NUMBER										b. AUTO ACCIDENT? PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME									
										YES NO																			
13 OTHER INSURED'S DATE OF BIRTH										c. OTHER ACCIDENT?										c. INSURANCE PLAN NAME OR PROGRAM NAME									
MM DD YY M F										YES NO																			
14 EMPLOYER'S NAME OR SCHOOL NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
																				YES NO If yes, return to and complete item 9 a-d									
d. INSURANCE PLAN NAME OR PROGRAM NAME										12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE										13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE									
										I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED										DATE										SIGNED									
14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE										16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
MM DD YY										MM DD YY										FROM MM DD YY TO MM DD YY									
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN										18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
I.M. Referring										12345678										FROM MM DD YY TO MM DD YY									
19 RESERVED FOR LOCAL USE										20 OUTSIDE LAB? \$ CHARGES										22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO									
										YES NO										23 PRIOR AUTHORIZATION NUMBER									
																				1234567									
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)										24 A DATE(S) OF SERVICE										B C D E F G H I J K									
										From To										Place of Service Type of Service									
										MM DD YY MM DD YY										CPT HCPCS MODIFIER									
										03 02 92 17 7 1 W9529										1 XX XX 2 11223344									
										03 15 92 17 7 1 W9523										1 XX XX 2 11223344									
										03 21 92 23 29 7 1 W9523										1 XX XX 9 11223344									
										03 16 92 7 1 W9512										1 XX XX 1 11223344									
25 FEDERAL TAX I.D. NUMBER										26 PATIENT'S ACCOUNT NO										27 ACCEPT ASSIGNMENT?									
										1234JED										YES NO									
28 TOTAL CHARGE										29 AMOUNT PAID										30 BALANCE DUE									
\$ XXX XX										\$ XX XX										\$ XXX XX									
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)										32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE									
I.M. Authorized																				I.M. Billing									
MM/DD/YY																				1 W. Williams									
SIGNED										DATE										Anytown, WI 55555									
																				87654321									

ATTACHMENT 2

**NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS
FOR THERAPY SERVICES**

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAF) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator

Enter claim sort indicator "D" (Durable Medical Equipment) or "T" (Therapy Services) for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S LD. NUMBER

Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME

Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

NOTE: A provider may submit claims for an infant if the infant is ten days old or less on the date of service and the mother of the infant is a Medical Assistance recipient. To bill for an infant using the mother's Medical Assistance identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the infant's date of birth in element 3. In element 4 enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's ten-digit Medical Assistance identification number.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS

Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME

Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, one of the following codes **MUST** be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage
OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE

When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-H	DENIED by the HMO or HMP for one of the following reasons: <ul style="list-style-type: none">- noncovered service- applied to deductible or copayment- family planning services (if WPS-HMP only)

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider.

When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook, this element may be left blank.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER

The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes **MUST** be indicated. The description is not required.

<u>Code</u>	<u>Description</u>
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Medicare disallowed (denied) service
M-8	Not a Medicare benefit

If a recipient's Medical Assistance identification card indicates no Medicare coverage, this element may be left blank. If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of this type of claim.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE

(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

When required, enter the referring or prescribing physician's name.

ELEMENT 17a - LD. NUMBER OF REFERRING PHYSICIAN

Enter the referring provider's eight-digit Medical Assistance provider number if certified by the WMAP. If the referring provider is not WMAP-certified, enter the provider's license number.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE

If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB

If laboratory services are billed, check either "yes" or "no" to indicate whether an outside lab was used.

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

The International Classification of Disease (ICD) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)**ELEMENT 23 - PRIOR AUTHORIZATION**

Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed are identical.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)

- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE

Enter the appropriate WMAP single-digit place of service code for each service.

Numeric	Description
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

ELEMENT 24C - TYPE OF SERVICE CODE

Enter the appropriate single-digit type of service code.

Numeric	Description
1	Medical (including: Injection, Physician's Medical Services, Home Health, Independent Nurses, Audiology, PT, OT, ST, Personal Care, Medical Day Treatment)
9	Other Services, including: Rehabilitation Agency

Alpha	Description
P	Purchase New DME
R	DME Rental

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES

Enter the appropriate five-character procedure code and, if applicable, a two-character modifier.

ELEMENT 24E - DIAGNOSIS CODE

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES

Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS

Enter the total number of services billed for each line. When billing procedure code 99000 (lab handling fee); indicate the number of labs in this element. A decimal must be indicated when a fraction of a whole unit is billed.

ELEMENT 24H - EPSDT/FAMILY PLANNING

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if BOTH HealthCheck and family planning services were provided. If HealthCheck/family planning do not apply, leave this element blank.

ELEMENT 24I - EMG

Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)**ELEMENT 24K - RESERVED FOR LOCAL USE**

Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)**ELEMENT 26 - PATIENT'S ACCOUNT NO.**

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT

(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER

The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

<u>HCPCS Code</u>	<u>Bi- lateral</u>	<u>Description</u>	<u>Rental/ Purchase Restrict.</u>	<u>Prior Auth. Req.</u>	<u>Life Expect.</u>	<u>N. Home Reimb.</u>	<u>Co- Payment</u>
W6849		Adaptive positioning equipment, unlisted procedure	P	*			\$1.00
<u>HOME HEALTH EQUIPMENT</u>							
E0179		Dry pressure pad or cushion, non-position (e.g., eggcarte)	P,R		1 year		\$50
W0905		Bathroom equipment, includes: rails, seats, stools, benches, any type	P,R	*	5 years		\$2.00
E0241		Bath tub wall rail, <u>each</u>	P		2 per lifetime		\$0.50
E0242		Bath tub rail, floor base, <u>each</u>	P		2 per lifetime		\$0.50
E0243		Toilet rail, <u>each</u>	P		2 per lifetime		\$0.50
E0244		Raised toilet seat	P		8 years		\$1.00
E0245		Tub stool or bench	P		5 years		\$1.00
E0246		Transfer tub rail attachment	P		1/lifetime		\$1.00
E1399	*	Durable medical equipment, not otherwise classified (claim must specify complete description of DME)	P,R	*		R	\$1.00
W6802		Bath chair (e.g. lounge-type - TLC chair)	P		8 years		\$1.00
E0746		Electromyography (EMG), biofeedback device	P,R	* **	8 years		\$1.00
W6814		Grab bars - <u>each</u>	P		8 years		\$1.00
W6824		Shower hose	P		1/lifetime		\$1.00
W6827		Transfer tub bench	P,R	* **	8 years	R	\$1.00
W6891	*	Consultant approved - DME purchase/rental	P,R	*		R	\$1.00

ATTACHMENT 3

MAPB-092-024-D
March 27, 1991

<u>HCPCS Code</u>	<u>Bi-lateral</u>	<u>Description</u>	<u>Rental/ Purchase Restrict.</u>	<u>Prior Auth. Req.</u>	<u>Life Expect.</u>	<u>N. Home Reimb.</u>	<u>Co- Payment</u>
W6849		Adaptive positioning equipment, unlisted procedure	P	*			\$1.00
<u>HOME HEALTH EQUIPMENT</u>							
E0179		Dry pressure pad or cushion, non-position (e.g., eggcrate)	P,R		1 year		\$50
W0905		Bathroom equipment, includes: rails, seats, stools, benches, any type	P,R	*	5 years		\$2.00
E0241		Bath tub wall rail, <u>each</u>	P		2 per lifetime		\$0.50
E0242		Bath tub rail, floor base, <u>each</u>	P		2 per lifetime		\$0.50
E0243		Toilet rail, <u>each</u>	P		2 per lifetime		\$0.50
E0244		Raised toilet seat	P		8 years		\$1.00
E0245		Tub stool or bench	P		5 years		\$1.00
E0246		Transfer tub rail attachment	P		1/lifetime		\$1.00
E1399	*	Durable medical equipment, not otherwise classified (claim must specify complete description of DME)	P,R	*		R	\$1.00
W6802		Bath chair (e.g. lounge-type - TLC chair)	P		8 years		\$1.00
E0746		Electromyography (EMG), biofeedback device	P,R	* **	8 years		\$1.00
W6814		Grab bars - <u>each</u>	P		8 years		\$1.00
W6824		Shower hose	P		1/lifetime		\$1.00
W6827		Transfer tub bench	P,R	* **	8 years	R	\$1.00
W6891	*	Consultant approved - DME purchase/rental	P,R	*		R	\$1.00

ATTACHMENT 3

MAPB-092-024-D
March 27, 1991

ATTACHMENT 4

PROCEDURE CODES IN WHICH REIMBURSEMENT
IS DETERMINED AT TIME OF PRIOR AUTHORIZATION

REHABILITATION AGENCIES

E1350 Repair or Non-Routine Service (e.g., breaking down)
E1360 Replacement, Supply or Accessory Necessary for Effective Use of Medically
Necessary Equipment Owned by
E1399 Durable Medical Equipment, Not Otherwise Classified

L1499 Unlisted Procedure for Spinal Orthosis
L2999 Unlisted Procedures for Lower Extremity Orthoses
L3999 Unlisted Procedure for Upper Limb Orthosis
L4210 Repair of Orthotic Device, Repair or Replace Minor Parts

W0905 Bathroom Equipment, Includes, Rails, Seats, Stools, Benches, any Type
W6634 Orthosis, Custom, Fabricated Additions/Modifications
W6808 Communicator (Including Accessories)
W6849 Adaptive/Positioning Equipment, Not Otherwise Classified
W6891 Consultant Approved-DME Purchase Not Otherwise Classified

PHYSICAL THERAPISTS

E1360 Replacement, Supply or Accessory Necessary for Effective Use of Medically
Necessary Equipment Owned by
E1399 Durable Medical Equipment, Not Otherwise Classified

L1499 Unlisted Procedure for Spinal Orthosis
L2999 Unlisted Procedures for Lower Extremity Orthoses
L3999 Unlisted Procedure for Upper Limb Orthosis
L4210 Repair of Orthotic Device, Repair or Replace Minor Parts

W6634 Orthosis, Custom, Fabricated Additions/Modifications
W6891 Consultant Approved-DME Purchase Not Otherwise Classified

OCCUPATIONAL THERAPISTS

E1360 Replacement, Supply or Accessory Necessary for Effective Use of Medically
Necessary Equipment Owned by
E1399 Durable Medical Equipment, Not Otherwise Classified
L1499 Unlisted Procedure for Spinal Orthosis
L2999 Unlisted Procedures for Lower Extremity Orthoses
L3999 Unlisted Procedure for Upper Limb Orthosis
L4210 Repair of Orthotic Device, Repair or Replace Minor Parts

W0905 Bathroom Equipment, Includes, Rails, Seats, Stools, Benches, any Type
W6634 Orthosis, Custom, Fabricated Additions/Modifications
W6849 Adaptive/Positioning Equipment, Not Otherwise Classified
W6891 Consultant Approved-DME Purchase Not Otherwise Classified

SPEECH/HEARING CLINICS

E1360 Replacement, Supply or Accessory Necessary for Effective Use of Medically
Necessary Equipment Owned by
E1350 Repair or Non-Routine Service (e.g., breaking down)
W6808 Communicator (Including Accessories)
W6891 Consultant Approved-DME Purchase Not Otherwise Classified
W6999 Unlisted Hearing Aid Services

SPEECH THERAPY

E1360 Replacement, Supply or Accessory Necessary for Effective Use of Medically
Necessary Equipment Owned by
E1350 Repair or Non-Routine Service (e.g., breaking down)
W6808 Communicator (Including Accessories)
W6891 Consultant Approved-DME Purchase Not Otherwise Classified

March 27, 1992

ATTACHMENT 5

PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO:

E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE

130

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890		4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow St. Anytown, WI 55555	
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A			
5 DATE OF BIRTH MM/DD/YY	6 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	8 BILLING PROVIDER TELEPHONE NUMBER (XXX) XXX-XXXX	
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Billing 1 W. Williams Anytown, WI 55555		9 BILLING PROVIDER NO. 12345678	
		10 DX: PRIMARY V537	
		11 DX: SECONDARY	
		12 START DATE OF SOI:	13 FIRST DATE RX:

14	PROCEDURE CODE	15	MOD	16	POS	17	TOS	18	DESCRIPTION OF SERVICE	19	OR	20	CHARGES
	W6635			3	P				Ischial containment/narrow M-L socket for knee disarticulation	1			XXXX.XX
	W6635			3	P				Ultra-light materials for KD	1			XXXX.XX
	W6635			3	P				Energy-storing foot	1			XXX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

TOTAL CHARGE 21 XXXX.XX

23 MM/DD/YY
DATE

24 *J.M. Requesting*
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION

☐
APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

☐
MODIFIED — REASON:

☐
DENIED — REASON:

☐
RETURN — REASON

DATE

CONSULTANT/ANALYST'S SIGNATURE

ATTACHMENT 5a

PRIOR AUTHORIZATION REQUEST FORM (PARF) APPROVAL SAMPLE

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE

130

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890		4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow St. Anytown, WI 55555	
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A		8 BILLING PROVIDER TELEPHONE NUMBER (XXX)XXX-XXXX	
5 DATE OF BIRTH MM/DD/YY	6 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	9 BILLING PROVIDER NO. 12345678	
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE. I.M. Billing 1 W. Williams Anytown, WI 55555		10 DX: PRIMARY V537	
		11 DX: SECONDARY	
		12 START DATE OF SOI:	13 FIRST DATE RX.

4 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 OR	20 CHARGES
W6635	11	3	P	Ischial containment/narrow M-L socket for knee disarticulation	1	med. cons. initials Price XXXX.XX
W6635	12	3	P	Ultra-light materials for KD	1	med. cons. initials Price XXXX.XX
W6635	13	3	P	Energy-storing foot	1	med. cons. initials Price XXXX.XX

2 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

TOTAL CHARGE 21 med. cons. initials Price ~~XXXX.XX~~

23 MM/DD/YY
DATE

24 J.M. Requesting
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☒
APPROVED

☐
MODIFIED

☐
DENIED

☐
RETURN

REASON:

REASON:

REASON:

mm/dd/yy
GRANT DATE

mm/dd/yy
EXPIRATION DATE

PROCEDURE(S) AUTHORIZED
as modified and priced
above

QUANTITY AUTHORIZED

mm/dd/yy
DATE

J.M. Consultant
CONSULTANT ANALYST SIGNATURE

ATTACHMENT 6

HAVING A LOWER PRIOR AUTHORIZATION THRESHOLD
Prior Authorization required if billed amount equals or exceeds \$150
for dates of services on or after May 1, 1992

REHABILITATION AGENCIES

E1350 Repair of Non-Routine Service (e.g., breaking down)
L4210 Repair of Orthotic Device, Repair or Replace Minor Parts
W6634 Orthosis, Custom, Fabricated Additions/Modifications

PHYSICAL THERAPISTS

L4210 Repair of Orthotic Device, Repair or Replace Minor Parts
W6634 Orthosis, Custom, Fabricated Additions/Modifications

OCCUPATIONAL THERAPISTS

L4210 Repair of Orthotic Device, Repair or Replace Minor Parts
W6634 Orthosis, Custom, Fabricated Additions/Modifications

SPEECH/HEARING CLINICS

E1350 Repair of Non-Routine Service (e.g., breaking down)

SPEECH THERAPY

E1350 Repair of Non-Routine Service (e.g., breaking down)